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In the Supreme Court of the United States

OCTOBER TERM, 1996

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES,
PETITIONER

v.

THE TOLEDO HOSPITAL

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Under a 1986 amendment to the Medicare Act, 42 U.S.C. 1395ww(h), Congress enacted a new methodology for reimbursing graduate medical education (GME) costs incurred by hospitals that participate in the Medicare program. The amendment directed the Secretary of Health and Human Services to "determine," for each hospital's cost reporting year that began during fiscal year 1984 (the base year), the "average amount recognized as reasonable" under the Medicare Act for direct GME costs for each full-time-equivalent resident. 42 U.S.C. 1395ww(h)(2)(A). The amendment further directed the Secretary to use that base-period per-resident amount, adjusted for inflation, to calculate the hospital's GME reimbursement for reporting periods beginning on or after July 1, 1985. 42 U.S.C. 1395ww(h)(2); see 42 C.F.R. 413.86. The question presented is:

Whether the Secretary reasonably construed 42 U.S.C. 1395ww(h) to authorize the reaudit of a hospital's previously approved (but possibly unreasonable or nonallowable) GME costs incurred in the base year, for the purpose of determining the reimbursement due in subsequent years.

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PETITION FOR A WRIT OF CERTIORARI

The Acting Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-21a) is reported at 104 F.3d 791. The opinion of the district court (App., *infra*, 22a-41a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on January 13, 1997. A petition for rehearing was denied on March 27, 1997. App., *infra*, 42a-43a. The juris-

diction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Relevant portions of Section 1395ww(h) of Title 42 of the United States Code and 42 C.F.R. 405.1885(a) and 413.86(e) are reproduced at App., *infra*, 44a-47a.

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services.[1] When eligible patients receive those services, the Secretary reimburses the providers of the services under the Medicare Act and the Secretary's implementing regulations. Under the regulations, the costs of certain educational programs for health professional trainees, including programs for interns and residents known as graduate medical education (GME) programs, are "allowable cost[s]" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a).

A provider's total allowable Medicare payment is based on a "cost report[]" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801(b). The cost report is filed with a "fiscal intermediary" (usually an insurance company) designated by the Secretary. It shows the provider's costs and the percentage of those costs allocated to Medicare services.

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[1] Part B is a voluntary supplementary insurance program covering physicians' services and other medical services.

42 C.F.R. 413.20(b), 413.24(f). The intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount to be paid for Medicare services during the reporting period. 42 C.F.R. 405.1803.

A provider dissatisfied with the NPR may timely request a hearing before the Provider Reimbursement Review Board (PRRB). 42 C.F.R. 405.1835, 405.1837. The PRRB's decision is "final," unless, within 60 days, the Secretary reverses, affirms, or modifies it. 42 U.S.C. 1395*oo*(f)(1). By regulation, a determination by the intermediary, the PRRB, or the Secretary may be "reopened" within three years (or at any time if there has been fraud) with respect to findings at issue in the determination. 42 C.F.R. 405.1807(b), 405.1885.[2]

2. From 1966 through 1982, providers of services under Part A ordinarily were reimbursed for Medicare-covered patient care to the extent the costs were reasonable. 42 U.S.C. 1395f(b)(1) (1982). The

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[2] Providers may obtain judicial review of any "final decision" of the PRRB or of the Secretary, if the Secretary exercises the right of review. 42 U.S.C. 1395*oo*(f)(1). They may also obtain expedited judicial review of any action taken by a fiscal intermediary "which involves a question of law or regulations relevant to the matters in controversy," if the PRRB determines that "it is without authority to decide the question" or fails to make a timely determination of its authority to decide the question. *Ibid.* The Board is authorized by regulation, 42 C.F.R. 405.1842(g)(2), to deny expedited judicial review if it finds that the issue on which review is sought is intertwined with disputed factual or legal issues that it is authorized to decide.

reasonable cost calculation generally was based on the "cost[s] actually incurred," as long as the services were necessary. 42 U.S.C. 1395x(v)(1)(A) (1982). The Act authorized the Secretary to issue regulations defining the payment due under that statutory standard. *Ibid.* In 1983, Congress introduced a prospective payment system (PPS) that establishes fixed payment rates for the operating costs of providing inpatient hospital care to program beneficiaries. See 42 U.S.C. 1395ww(d). Costs incurred in connection with GME programs were excluded from the PPS scheme. 42 U.S.C. 1395ww(a)(4) and (d)(1)(A). Until July 1985, GME costs continued to be reimbursed on a "reasonable cost" basis.

In the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, however, Congress changed the method for calculating GME costs by providing that, subject to updating for inflation, the calculation of GME costs to be reimbursed in all subsequent years would be based on the amount of allowable GME costs incurred by the provider for a fiscal year that began between October 1, 1983, and September 30, 1984 (the base year). See Medicare and Medicaid Budget Reconciliation Amendments of 1985 (MMBRA), Pub. L. No. 99-272, Tit. IX, § 9202(a), 100 Stat. 171-175, 42 U.S.C. 1395ww(h) (the GME Amendment); see also 42 C.F.R. 413.86(e)(1)(i)(A). Specifically, the GME Amendment provides, as the initial step in the reimbursement process, that "[t]he Secretary shall determine [for the base year] the average amount recognized as reasonable" under the Act for direct GME costs for each full-time-equivalent (FTE) resident. 42 U.S.C. 1395ww(h)(2)(A). Thus, the Secretary was directed to calculate a per-resident amount for each hospital by dividing the

amount of GME costs "recognized as reasonable" for the base period of 1984 (numerator) by the number of FTE interns and residents working at the hospital in 1984 (denominator). To determine a hospital's GME reimbursement for any given year, the allowable GME per-resident amount, adjusted for inflation, is multiplied by the number of FTE residents working in the hospital during the year in question and the hospital's Medicare patient load that year. 42 U.S.C. 1395ww(h)(3). Congress instructed the Secretary to apply the new method retroactively to "hospital cost reporting periods beginning on or after July 1, 1985." MMBRA, § 9202(b), 100 Stat. 175, 42 U.S.C. 1395ww note.

On September 21, 1988, the Secretary published and invited comment on proposed regulations implementing the GME Amendment. 53 Fed. Reg. 36,589 (1988). Although the Secretary already had reimbursed most hospitals for 1984 GME costs, and in some cases the three-year period for administratively reopening the determinations relevant to those payments had expired, the proposed regulations authorized fiscal intermediaries to reexamine providers' costs from the base year and to conduct a reaudit if the claimed base year costs appeared to include "misclassified or nonallowable costs," or were "unreasonably high." *Id.* at 36,592. The Secretary explained that the agency had reason to believe some "questionable" GME costs had been "erroneously reimbursed" to providers for the base year. *Id.* at 36,591. Because the Secretary concluded that those past mistakes should not be "perpetuated" under the new GME cost reimbursement methodology, the reauditing authority was needed to ensure an "accurate" determination of providers' base-year GME costs. *Id.* at 36,591-36,592.

The Secretary believed that "the provisions of [Section 1395ww(h)] would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later." *Id.* at 36,593.

In the preamble to the final regulations, issued on September 29, 1989 (see 54 Fed. Reg. 40,286-40,301, 40,316 (1989); 42 C.F.R. 413.86), the Secretary reiterated that it was "hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely." 54 Fed. Reg. 40,301 (1989). The Secretary assured providers that, in reauditing 1984 GME costs, "no new reimbursement principles will be applied * * * [;] [r]ather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied." *Ibid.* In response to comments that the proposed reexamination and reaudits conflicted with the three-year reopening limitation in 42 C.F.R. 405.1885, the Secretary stressed that the reaudits would not be used to recoup erroneous reimbursement for cost reports that had been settled for more than three years under the reopening regulation. 54 Fed. Reg. 40,302 (1989). Rather, they would be used to recalculate base year costs "solely for purposes of computing the per resident amount" under the new method for reimbursing GME costs for 1985 and "subsequent years still subject to reopening." *Id.* at 40,301-40,302.[3]

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[3] The Secretary also permitted hospitals to request a reopening of a cost report settled more than three years before reaudit if the reaudit resulted in a disallowance based on "misclassified" base-period GME costs. 54 Fed. Reg. 40,301 (1989). The purpose of that modification was to allow the

In late 1990, fiscal intermediaries began to conduct redeterminations of GME base-year amounts for teaching hospitals that provide Medicare services, including respondent, The Toledo Hospital. The reaudit of respondent resulted in a determination that respondent's allowable GME costs for its base year were $4,278,371, which was $1,589,334 less than the $5,867,705 in GME costs the intermediary approved on February 26, 1986. App., *infra*, 4a-5a.[4] On July 26, 1991, respondent appealed the intermediary's determination to the PRRB. Respondent challenged the validity of the GME regulation authorizing the reaudit, arguing that the GME Amendment required the Secretary to determine respondent's average amount of reasonable GME costs for the base period by using the amount reflected in respondent's NPR for the base period and reimbursed by the Secretary, and not the amount resulting from the reaudit. On December 17, 1993, the PRRB concluded that it lacked authority to invalidate the GME regulation, thereby allowing respondent to seek expedited judi-

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hospitals to demonstrate that, if the reaudit showed the disallowed cost should have been classified as an operating rather than a GME cost, their reimbursement rate for operating costs should be increased. *Ibid.*

[4] Although it was evident that respondent had received excessive reimbursement for 1984 GME costs, no recoupment action was taken against it by the intermediary or the Secretary because respondent's 1984 cost report had been settled for more than three years and could not be reopened under 42 C.F.R. 405.1885. Instead, the intermediary notified respondent that it would use the reaudited GME cost amount solely to determine respondent's reimbursable GME amount for all cost reporting years beginning on or after July 1, 1985, for which the three-year reopening period had not already elapsed. Compl. ¶ 39; see 42 C.F.R. 413.86(e)(1)(iii).

cial review under 42 U.S.C. 1395oo(f)(1). App., *infra*, 5a-6a; see note 2, *supra*.

3. Respondent filed suit in the United States District Court for the Northern District of Ohio, challenging the validity of the GME reaudit regulation. On the parties' cross-motions for summary judgment, the district court upheld the GME reaudit regulation. App., *infra*, 22a-41a. Approaching the issue under the two-step analysis set forth in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the district court found that the GME Amendment is silent or ambiguous with respect to reaudits, and that the reaudit regulation reflects a reasonable construction of the GME Amendment. The district court concluded that the Secretary's belief "that Congress did not intend for misclassified and nor-allowable costs to be permanently ingrained in future reimbursements" was "reasonable and consistent with the congressional purpose of limiting payments to hospitals for [GME] costs." App., *infra*, 34a (citing *Administrators of the Tulane Educational Fund* v. *Shalala*, 987 F.2d 790, 797 (D.C. Cir. 1993), cert. denied, 510 U.S. 1064 (1994)). The district court also expressed the view that the reauditing process reasonably resulted in "two different, but equally allowable, determinations of a hospital's base year GME costs," because "the corrected amount will only be applied in cost reporting years still subject to reopening." App., *infra*, 36a. Finally, the court determined that the GME regulation was not an exercise in impermissible retroactive rulemaking because it has "no retrospective impact other than that mandated by statute (i.e. the results of the reaudit are applied only to cost reporting years beginning on or after July 1, 1985)." *Id.* at 38a.

4. The court of appeals reversed. App., *infra*, 1a-21a. The court of appeals recognized (*id.* at 11a) that the decision upon which the district court relied, *Administrators of the Tulane Educational Fund* v. *Shalala*, *supra*, has been "explicitly adopted" by the Eighth Circuit in *St. Paul-Ramsey Medical Center, Inc.* v. *Shalala*, 91 F.3d 57 (1996), petition for cert. granted, No. 96-1375 (June 2, 1997). It concluded, however, that the GME reaudit regulation fails *Chevron*'s two-step analysis. Finding "no ambiguity in the language 'recognized as reasonable under this subchapter,'" the court of appeals read the GME Amendment to the Act to require the Secretary to determine the per-resident amount based on "a simple calculation * * * arrived at through the normal administrative process." App., *infra*, 12a; see *id.* at 12a-17a. Alternatively, the court of appeals concluded that the reaudit regulation "is an unreasonable interpretation of the GME Amendment." *Id.* at 18a; see *id.* at 17a-21a. The court of appeals rejected the Secretary's contention that reaudits are necessary to prevent erroneous cost determinations from being perpetuated in the form of excessive future reimbursements, and concluded that "the principle of issue preclusion prevents the Secretary from requiring providers to reestablish the costs that they already proved years ago." *Id.* at 19a. Similarly, the court of appeals stated that "because the Secretary waited three years before issuing [the GME] regulations," *id.* at 19a-20a, "it is unreasonable to expect the Hospital to answer" for any errors in its base year calculation, *id.* at 21a.

REASONS FOR GRANTING THE PETITION

This case presents the same question that is presented in *St. Paul-Ramsey Medical Center, Inc.* v. *Shalala*, petition for cert. granted, No. 96-1375 (June 2, 1997). Both cases concern whether the Secretary reasonably construed 42 U.S.C. 1395ww(h) to authorize the reaudit of a hospital's previously approved GME costs incurred in the base year, for the purpose of determining the reimbursement due in subsequent years. In the instant case, the court of appeals disagreed with the Eighth Circuit's decision in *St. Paul-Ramsey* and concluded that the Secretary's GME reaudit regulation is invalid under *Chevron*'s two-step analysis. Because the Court's resolution of *St. Paul-Ramsey* will govern the disposition of this case, the petition in this case should be held pending the decision in *St. Paul-Ramsey* and then disposed of in light of that decision.[5]

CONCLUSION

The petition for a writ of certiorari should be held pending the decision in *St. Paul-Ramsey Medical Center, Inc.* v. *Shalala*, No. 96-1375, and then disposed of as appropriate in light of the decision in that case.

Respectfully submitted.

WALTER DELLINGER
Acting Solicitor General

JUNE 1997

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[5] Counsel for respondent also represents the petitioner in *St. Paul-Ramsey* and accordingly is familiar with the certiorari petition and our brief acquiescing in certiorari in that case.

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 95-3858

THE TOLEDO HOSPITAL, PLAINTIFF-APPELLANT,

v.

DONNA E. SHALALA, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLEE

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO

[Decided and filed: ~~Jan~~. 13, 1997]

Before: BOGGS and NORRIS, Circuit Judges; HOOD, District Judge.*

ALAN E. NORRIS, Circuit Judge.

At issue in this case is the validity of the Medicare reaudit regulation, 42 C.F.R. §§ 413.86(e)(1)(ii)-(iii). For the following reasons, we conclude that the reaudit regulation is invalid under the guidelines set

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* The Honorable Joseph M. Hood, United States District Judge for the Eastern District of Kentucky, sitting by designation.

out by the Supreme Court in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

I. Regulatory Framework

From 1965 to 1986, the Medicare program reimbursed participating hospitals, known as providers, for the reasonable costs incurred in furnishing graduate medical education ("GME"). The Secretary of Health and Human Services (the "Secretary") delegated the task of administratively determining these costs to fiscal intermediaries. The procedure for determining a provider's reasonable costs for GME involved several steps. First, providers would submit a cost report to a fiscal intermediary shortly after the end of the reporting year. *See* 42 C.F.R. § 413.24(f)(2)(i) (1995). The fiscal intermediary would then issue a notice of program reimbursement (an "NPR"). *See* 42 C.F.R. § 405.1803(a) (1995). A provider dissatisfied with the allowed costs could appeal the intermediary's determination to the Provider Reimbursement Review Board (the "Board"). *See* 42 U.S.C. § 1395*oo*(a)(1); 42 C.F.R. § 405.1835(a) (1995). Judicial review of final decisions of the Board was authorized by 42 U.S.C. § 1395*oo*(f)(1).

To aid in the audit and review of providers' claims, the Secretary required each provider to retain records pertaining to its physicians' compensation, as well as the amount of time each physician devoted to Medicare versus non-Medicare duties. 42 C.F.R. § 405.481(g)(3) (1995), *removed*, 60 Fed. Reg. 63,124, 63,175 (1995). The Secretary required that such records be retained for at least four years after the end of each cost reporting period to which the allocation applies. *Id.* To further ensure the accuracy of the

audit process, the Secretary allowed for the reopening of a cost determination within three years of the last administrative action taken with respect to the year in question. *See* 42 C.F.R. § 405.1885(a) (1995).

In April of 1986, Congress enacted the Comprehensive Omnibus Budget Reconciliation Act of 1986 (the "Act"), Pub. L. No. 99-272, 1986 U.S.C.C.A.N. (100 Stat.) 82. Among the changes adopted, the Act converted GME reimbursements from a pass-through basis to a per-resident reimbursement indexed to a base year. Section 9202(a) of that act amended § 1886 of the Social Security Act, 42 U.S.C. § 1395ww, by, among other things, enacting 42 U.S.C. § 1395ww(h)(2)(A), the current version of which reads as follows: "The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 1986 U.S.C.C.A.N. (100 Stat.) at 171-72 (the "GME amendment"). Section 9202(a) further provides that the base year per-resident average would be adjusted for inflation and used to calculate GME reimbursements for future years. *See* 42 U.S.C. §§ 1395ww(h)(2)(C)-(D). Section 9202(b) of the Act provides that the amendments in § 9202(a) "shall apply to hospital cost reporting periods beginning on or after July 1, 1985." 1986 U.S.C.C.A.N. (100 Stat.) at 175.

While the Act was passed in April of 1986, the Secretary waited until September of 1989 to adopt implementing regulations. *See* 54 Fed. Reg. 40,286, 40,316-17 (1989) (Codified at 42 C.F.R. § 413.86(e)(1)). These regulations first instruct the fiscal intermediaries to verify that the costs allowed for each provider

for the base year, fiscal year 1984, are accurate and to exclude any costs improperly allowed in the initial audit. *See* 42 C.F.R. §§ 413.86(e)(1)(i)-(ii) (1995). The regulations then address GME cost determinations that are more than three years old and, therefore, are no longer subject to reopening: "If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount." 42 C.F.R. § 413.86(e)(1)(iii) (1995) (together with 42 C.F.R. § 413.86(e)(1)(ii), the "reaudit regulation"). Thus, finding that a provider's 1984 GME costs were too high would not require repayment from the provider for that year if the reaudit occurred after the end of the reopening period. Because many providers had disposed of their records for 1984 after having retained the documents for the requisite four-year period, the Secretary allowed providers who no longer had their 1984 records to submit information from subsequent years as evidence of the number of residents and the percentage of time dedicated to Medicare activities for the base year. *See* 55 Fed. Reg. 35,990, 36,063-64 (1990).

II. Facts

Plaintiff, The Toledo Hospital (the "Hospital"), uses the calendar year as its fiscal year. Accordingly, its base year for purposes of the Medicare regulations ended on December 31, 1984. On February 26, 1986, a fiscal intermediary issued the NPR for 1984, recognizing that the Hospital was entitled to $5,867,705 in reasonable GME costs. The Hospital did not appeal that finding to the Board, and the three-year reopening period for the 1984 determi-

nation ended on February 26, 1989. Under the four-year record-keeping requirement, the Hospital was required to retain its physician compensation records for 1984 until December 31, 1988.

Pursuant to the reaudit regulations adopted in September of 1989, a fiscal intermediary began a reaudit of the Hospital's base year in late 1990. On January 31, 1991, the intermediary found that the initial determination of the Hospital's base-year cost was nearly forty percent too high and that the appropriate GME costs for 1984 were $4,278,371. Based upon this adjusted cost figure and the number of full-time-equivalent residents for 1984, the intermediary determined an average per-resident GME amount that results in substantially lower GME reimbursements to the Hospital for cost years beginning on January 1, 1986, than would have been the case if the original cost figure had been used.

The Hospital appealed the fiscal intermediary's reaudit calculation to the Board. On December 17, 1993, the Board ruled that it lacked authority to decide the validity of the Secretary's reaudit regulation, thereby allowing for immediate judicial review in the district court. *See* 42 U.S.C. § 1395*oo*(f)(1). Shortly thereafter, the Hospital filed this suit in the United States District Court for the Northern District of Ohio seeking both declaratory and injunctive relief. The Hospital argued that (1) the reaudit regulation is impermissibly retroactive, (2) the regulation conflicts with the Medicare statute, and (3) the regulation is arbitrary and capricious. On March 27, 1995, the Hospital filed a motion for summary judgment, and the Secretary filed a cross-motion for summary judgment on March 30, 1995. On June 23, 1995, the district court issued an order granting

summary judgment in favor of the Secretary and denying the Hospital's summary judgment motion. The Hospital filed this appeal.

III. *Chevron* Analysis

We review the district court's grant of summary judgment de novo. *See Holiday Inns, Inc. v. 800 Reservation, Inc.*, 86 F.3d 619, 622 (6th Cir. 1996). Because the denial of the Hospital's motion for summary judgment was based entirely upon a ruling of law, rather than the presence of factual issues for trial, we review that decision de novo as well. *See Greene v. Reeves*, 80 F.3d 1101, 1104 (6th Cir. 1996). The familiar standard for assessing the validity of federal regulations appears in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43 (footnotes omitted). Moreover, "[i]f a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Id.* at 843 n.9.

The Hospital argues that *Chevron* does not apply in the present case because of the retroactive nature of the reaudit regulation. Although courts generally do not defer to retroactive agency regulations when the statutes that they implement do not require retroactive application, the reaudit regulation does not amount to an impermissible retroactive regulation. In *Landgraf v. USI Film Products*, 114 S. Ct. 1483 (1994), the Supreme Court defined the test for retroactivity as "whether the new provision attaches new legal consequences to events completed before its enactment." *Id.* at 1499. While the reaudit regulation does require a determination based upon events occurring in the base year, it does not change the standards under which the base year costs are to be determined. Thus, we believe that *Chevron* applies in this case.

A. Step One: Plain Meaning

The first step in the *Chevron* analysis is to determine whether Congress has expressed an intent on the issue at hand. That intent can appear in the language of the statute, or it can become apparent in light of the statutory scheme taken as a whole. The GME amendment directs the Secretary "to determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42

U.S.C. § 1395ww(h)(2)(A). The Hospital contends that the plain meaning of this language prohibits the Secretary's reaudit regulation, which directs the fiscal intermediaries to recalculate the 1984 GME costs even after the three-year reopening period has expired.

Determining whether a statute is unambiguous is not always an easy matter. The first court to address the validity of the reaudit regulation, the District Court for the District of Columbia, held that the regulation contradicts the plain language of the statute. *See Methodist Hosps. v. Sullivan*, 799 F. Supp. 1210, 1216-17 (D.D.C. 1992), *rev'd sub nom. Administrators of the Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). In reversing the district court, however, the Court of Appeals for the District of Columbia discovered ambiguity in the words "determine," "recognized as reasonable," and "under this subchapter." *Administrators of the Tulane Educ. Fund v. Shalala*, 987 F.2d 790, 794-96 & n.6 (D.C. Cir. 1993), *cert. denied*, 510 U.S. 1064 (1994). The next three courts to address this issue, beginning with the district court in the case at bar, relied heavily upon the reasoning in *Tulane* and concluded that the statute is ambiguous. *See Toledo Hosp. v. Shalala*, No. 3:94CV7080, slip op. at 8-9 (N.D. Ohio June 23, 1995); *St. Paul Ramsey Medical Ctr., Inc. v. Shalala*, 1995 WL 879969, at 2 (D. Minn. Aug. 8, 1995), *aff'd*, 91 F.3d 57 (8th Cir. 1996); *St. Paul-Ramsey Medical Ctr., Inc. v. Shalala*, 91 F.3d 57 (8th Cir. 1996).

Before proceeding with our own examination of the GME amendment, we consider it worthwhile to review the approaches taken by the two courts of appeals that have had occasion to address the validity of

the reaudit regulation. The Court of Appeals for the District of Columbia in *Tulane* began its analysis with the following summary:

> [W]e do not believe that Congress spoke directly to the precise question of whether HHS should, in determining the base period GME per resident amount, automatically adopt the GME sum approved for reimbursement to hospitals for 1984 or whether it retained the residual authority to reassess at a later date the reasonableness of that calculation for prospective use only. *Given this ambiguity*, we find that HHS reasonably determined that Congress would not likely have wished misclassified and nonallowable costs inadvertently reimbursed to hospitals for fiscal year 1984 to be "cemented" into the base period amount and indefinitely carried forward in the formula for future reimbursements. *To avoid that eventuality, HHS must retain the ability to revisit its 1984 reimbursements for error*, even though those figures had previously been found reasonable, since the sole purpose of the reauditing was to calculate the base period formula applicable under the 1986 statute for fiscal year 1985 and later years.

987 F.2d at 792 (emphasis added).

The court identified the crux of the matter as follows:

> The issue thus devolves into whether, assuming its knowledge of the long-standing regulation providing for a three year period for reopening approved costs, 42 C.F.R. § 405.1885, Congress in enacting the 1986 GME Amendments left some leeway for the eventuality that HHS might not be

> able to promulgate and implement regulations governing the new methodology until after that three year period had lapsed, or whether, even if the new regulations should be delayed until after the three year period, Congress clearly intended to prohibit the Secretary from reauditing the 1984 costs for past errors in order to establish an accurate base period per resident amount.

Id. at 794. The court then identified the purpose of the 1986 statute as to establish "a new and presumably more accurate methodology for reimbursing GME costs. . . ." *Id.* at 795. The court concluded that there is no evidence that Congress meant to preclude the Secretary from revisiting the 1984 cost determinations.

The court then went on to note that the statutory language is ambiguous:

> Finally, and perhaps most importantly, the relevant phrase "amount recognized as reasonable under this subchapter" is on its face ambiguous. We know only one thing for sure, that it certainly could not have included any amounts already finally approved before the statute was enacted since, in 1986, every hospital's 1984 NPR was still subject to the three year reopening period. *See* 42 C.F.R. § 405.1885. But beyond that given, it is decidedly unclear that the statute meant to allow the Secretary to use only the GME cost figure that would emerge as reasonable through the regular NPR review and three year reopening process. It might just as well have permitted the Secretary the option of using a figure that would be "recognized as reasonable under

> this title" at a later time after more careful assessment.

Id. at 796.

In a footnote, the court also considered the ambiguity of the word "determine":

> We also note that because the statute directs the HHS to "determine" the "average amount" of GME costs per FTE resident "recognized as reasonable," it seems unlikely that Congress intended for the HHS to simply look up a hospital's approved NPR for 1984 and plug it into the statutory formula. This activist language suggests that Congress must have intended for the agency to make some kind of substantive calculation on its own, which might involve as well a current assessment of the reasonableness of prior determinations.

Id. at 796 n.6.

The Court of Appeals for the Eighth Circuit explicitly adopted the reasoning of *Tulane* in *St. Paul-Ramsey Medical Ctr., Inc. v. Shalala*, 91 F.3d 57, 58 (8th Cir. 1996).

With due respect to our sister courts, we believe that the approach taken by the court in *Tulane* misperceives the policy underlying *Chevron* deference. *Chevron* instructs courts to accept a reasonable administrative interpretation of a statute where Congress has delegated decisional autonomy to an agency. When Congress intentionally leaves gaps and ambiguous terms in a statute for the agency to flesh out, the principle of separation of powers counsels that this legislative delegation be respected by the judiciary. It is an entirely different matter, however, to presume a delegation of interstitial rulemaking

authority when the claimed ambiguity in the statute stems not from the use of a word with several plausible interpretations, nor from the statute's lack of specificity regarding mundane procedural issues, but from nothing more than the failure of Congress to proscribe explicitly an unusual procedure which may be plainly at odds with the result Congress was trying to reach.

It seems to us that when the court in *Tulane* parsed the GME amendment, it failed to accord proper attention and importance to the word "average," a term that is critical to understanding congressional intent. The GME amendment, in establishing a reimbursement scheme keyed to a base-year figure, introduced the concept of the per-resident average cost. This concept had not been used previously in the calculation of reimbursements and became the basis for all future payouts. Upon fulfilling the obligation imposed by the GME amendment, the Secretary would arrive at this number, the per-resident average, which would then be adjusted for inflation and utilized to determine future reimbursements. Given the introduction of this entirely new cost concept, we do not believe that the *Tulane* court was warranted in seizing upon the word "determine" as "activist language" that would authorize agency action that goes far beyond a simple calculation of the per-resident average based upon 1984 figures arrived at through the normal administrative process. *See Tulane*, 987 F.2d at 796 n.6.

We also see no ambiguity in the language "recognized as reasonable under this subchapter." While the court in *Tulane* felt that the temporal focus of this language was open-ended, thereby permitting the incorporation of substantive regulatory standards

formulated at any time, including after the enactment of the GME amendment, that interpretation is strained at best. While we agree that the use of the past participle "recognized" does not restrict the Secretary to using numbers that had been finally determined prior to the passage of the GME amendment, as all of the base-year determinations were still subject to administrative reopening in 1986, there is no basis for the additional inferential leap that the Secretary was therefore free to "recognize" these costs at any time in the future and in a manner utterly detached from the established procedural framework.

When Congress passed the GME amendment in 1986, it knew that there was an administrative scheme in place that would determine the reasonable GME costs for providers for fiscal 1984. And one must assume that Congress also knew that the 1984 determinations would remain subject to reopening for over a year under the Secretary's existing regulations. It follows that Congress must have contemplated that the Secretary would use those administratively determined reasonable costs as the basis for calculating the average GME cost per full-time-equivalent resident. Indeed, it seems unlikely that Congress, having chosen for its benchmark a cost year still subject to reopening under the existing Medicare regulations, would have been contemplating anything else when it passed the amendment.

The strongest argument for ambiguity may stem from an inference that, because Congress must have understood that regulations might not be forthcoming until after the 1984 cost determinations had ceased to be subject to reopening, it intended that the Secretary would have the authority to reaudit the

base-year numbers. That argument is circular, however, as it presupposes that Congress intended the GME amendment to require a reassessment of the 1984 costs. Only if the amendment would assign to the Secretary a new and substantial administrative burden would there be a congressional expectation that implementing regulations would take any real time to formulate. The Secretary argues that a three-year delay in enacting implementing regulations is understandable and foreseeable in light of the "complex statutory scheme," a phrase that seems to be invoked any time a statute occupies more than a page of the United States Code. However, the statute and its contemplated result are not at all complex. A major overhaul of the Medicare system might entitle the Secretary to consume a considerable amount of time in preparing regulations. That surely is not the case with the GME amendment, which merely directs the Secretary to divide one number by another. Moreover, if, as it seems clear to us, Congress intended the actual 1984 costs to be plugged into the per-resident average calculation, it was not attempting to create work for the Secretary with respect to the cost determination. And it follows that, since there was no such extra work contemplated and there was no reason to suppose that promulgating regulations would consume three years, there was no reason to address in the statute the specific issue of authority to reaudit closed base years.

What the Secretary is really saying is that Congress must have contemplated that the administrative mechanism to determine reasonable GME costs, created by Congress and implemented by the Secretary's regulations, might not work as well as planned. The Secretary's argument concedes that

her agents, the fiscal intermediaries, were not as diligent as they could have been when they initially audited the 1984 numbers. The rationale offered by the Secretary is that because each year's cost determination formerly had no impact beyond that year, it was not as important at that time to get the numbers exactly right. Only now, when Congress has designated a base year that will affect future reimbursements, has it become essential that the fiscal intermediaries root out errors. However, when the statutory language is read in the context of the circumstances surrounding its adoption, it is difficult to come to any conclusion other than that Congress anticipated that the administrative scheme already in place would function properly and arrive at the true reasonable GME costs for fiscal 1984 and that these numbers would then be divided by the number of residents to yield the per-resident average costs. Congress could not have foreseen the Secretary's delay in issuing the regulations and her claim that the initial 1984 cost determinations were unreliable. Otherwise, it might well have authorized the reaudit scheme, or simply have selected a different base year.

The Secretary suggests that there was no choice but to reaudit, given the delay in issuing the regulations. It would not be "reasonable" under the GME amendment, the argument runs, to use a base-year cost figure that had since been discovered to be unreliable, so the statute required a recalculation. The answer to that argument is that the Secretary was without authority to issue the reaudit regulation. The Secretary should have either used the administratively determined 1984 figure or informed Congress of the need for further legislation.

The intent of Congress in enacting the GME amendment should also be considered in the context of the traditional presumption of issue preclusion with respect to administrative findings, since "Congress is understood to legislate against a background of common-law adjudicatory principles." *Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 108 (1991). It seems to us that, absent some indication from Congress that administrative findings were not to be given preclusive effect, courts should be hesitant to permit administrative agencies to require a party to reestablish or relitigate factual matters that have already been determined with finality. *See id.* at 107-08. We are unable to accept the Secretary's suggestion that estoppel does not apply because the incentive to determine the issue correctly did not exist during the initial audits, or was not as strong, when each year's cost determination had no effect beyond that year. *See United States v. Berman*, 884 F.2d 916, 922-23 (6th Cir. 1989). After all, the Secretary was directed by statute to determine the reasonable costs for GME, a factual question identical to the determination in the reaudit regulation and one that the Secretary was required by law to resolve. The absence of statutory language negating the presumption of issue preclusion strongly suggests that Congress intended the Secretary to use the 1984 costs derived through the ordinary administrative process.

Finally, it is difficult to imagine that, had Congress intended the result urged by the Secretary, it would have used the language that ultimately found its way into the statute. Instead, a statute focusing on reaudits possibly leading to new, reasonable cost figures, could be expected to include directions to the Secretary to "determine, for the hospital's cost

reporting period that began during fiscal year 1984, the amount recognized as reasonable under this subchapter for graduate medical education and the average cost of graduate medical education for each full-time-equivalent resident," or something similar. Surely, such a statute would not, as did the actual GME amendment, direct the Secretary to "determine" solely "the average amount." It seems apparent that the only substantive calculation contemplated by the statute is this per-resident average, and there is no basis for asserting that the 1984 figures should be reassessed outside the existing administrative scheme.

Under *Chevron* analysis, a regulation does not survive the first step merely because there is a metaphysical possibility that the statute could be read in the manner advocated by the agency. The GME amendment does not, by its terms, explicitly proscribe the reaudit that occurred in this case. Nevertheless, the statutory framework, as well as the regulations in place at the time that the GME amendment was enacted, provide clear illumination of the will of Congress. When this court can readily discern that an agency has strayed from the path intended by Congress, the inference of legislatively delegated authority vanishes. In the absence of delegated authority, *Chevron* deference is not warranted. Accordingly, we believe that the reaudit regulation is inconsistent with the legislative intent behind the GME amendment, and thus that it fails under the first prong of *Chevron*.

B. Step Two: Reasonableness

When a regulation satisfies step one of *Chevron*, the analysis shifts to a determination of whether the

agency's construction of its statute is reasonable. The review for reasonableness examines whether the agency properly exercised its discretion within the sphere of its delegated authority. Review of this question centers on whether the agency action either "fills a gap" or otherwise fits within "the legislature's revealed design." *NationsBank of North Carolina v. Variable Annuity Life Ins. Co.*, 115 S. Ct. 810, 813-14 (1995). Although we have concluded that the reaudit regulation fails at the first step of *Chevron*, we hold in the alternative that the reaudit regulation is an unreasonable interpretation of the GME amendment.

The two key considerations that led the court in *Tulane* to conclude that the reaudit regulation satisfies the second prong of *Chevron* were (1) the interest in preventing erroneous cost determinations from being perpetuated in the form of excessive future reimbursements and (2) the time needed by the Secretary to regulate within a "complex statutory scheme." *Tulane*, 987 F.2d at 797. The Secretary argues that a failure to reaudit would have been unreasonable, given the presumed intent of Congress to eliminate mistakes in the base-year calculations. The Secretary notes that the reaudits have resulted in many instances in findings of much lower base-year costs than were originally determined through the normal administrative mechanism. The Secretary also argues that it could have amended the reopening regulation to allow for a longer reassessment window. The district court in this case also stressed that the hospitals had at least some notice of the possibility of reauditing, *see* 53 Fed. Reg. 36,589, 36,591-92 (1988), and thus should have retained their

physician compensation allocation records beyond the four-year period.

The Hospital responds that, because (1) the records have been disposed of, (2) many of the relevant hospital personnel have moved to other jobs, and (3) memories of what specific duties residents performed in 1984 have faded, there is no way that a reaudit would produce a more accurate assessment of 1984 costs than did the initial audits. As for the lower costs determined by the reaudits, the Hospital argues that the result necessarily follows from the absence of supporting documentation. Only those costs that could be proved were allowed in the reaudit, and without any records the Hospital could no longer prove as much of its GME costs as it was able to do in the original audit.

The Secretary is obviously correct that Congress did not want faulty base-year calculations to be perpetuated. What the Secretary fails to recognize is that Congress expected the Secretary to get the calculations right the first time. There is no claim that the Hospital tried to deceive the fiscal intermediary by submitting a fraudulent cost report for 1984, and the regulations expressly allow for reopening at any time where fraud is shown. *See* 42 C.F.R. § 405.1885(d) (1995). The Secretary simply claims that it was swamped with work, including coping with earlier amendments to the Medicare statute, that resulted in less attention being paid to the initial cost determinations for 1984. We believe that the principle of issue preclusion prevents the Secretary from requiring providers to reestablish the costs that they already proved years ago.

The other significant problem with the Secretary's argument is that the whole reaudit issue arose be-

cause the Secretary waited three years before issuing regulations. Had the Secretary acted promptly, there would have been no need to revisit any closed determinations, because all of the 1984 numbers were still subject to reopening for some time after the passage of the GME amendment. Even after the Secretary recognized that there might be problems with the 1984 numbers and that reaudits may be necessary, there was a delay of at least a year before the reaudit regulation was enacted. *See* Fed. Reg. 36, 589, 36, 591-92 (1988) (indicating that errors had been made in previous audits). During that year, many, if not most, of the 1984 determinations ceased to be subject to reopening.

The bottom line is that the Secretary's response to the GME amendments has been unreasonable on all counts. The Secretary read the amendments as requiring a substantive reevaluation of the 1984 numbers. The Secretary waited far too long to issue regulations, justified solely by the nebulous assertion of statutory and regulatory complexity. While there was a brief mention in the Federal Register of the possibility of reaudits once the Secretary came to suspect that the base-year calculations may have been flawed, those comments cannot be considered notice of the need to retain physician allocation and compensation records when all that the Secretary would have had to do to mitigate the harm here was to (1) extend the reopening period, (2) extend the record-keeping period, or (3) reopen all of the 1984 determinations. The Secretary ignored the principle of collateral estoppel and the basic fairness issues implicated. Finally, the Secretary ordered the reaudits to occur only after the providers had been permitted to dispose

of the records necessary to allow for a meaningful audit.

The predicament was of the Secretary's making and it is unreasonable to expect the Hospital to answer for it. Accordingly, we believe that the reaudit regulation fails step two of *Chevron*.

IV. Conclusion

The judgment of the district court, granting summary judgment to the Secretary and denying summary judgment to the Hospital, is **reversed**. The cause is **remanded** with instructions to grant summary judgment to the Hospital.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

No. 3:94CV7080

THE TOLEDO HOSPITAL, PLAINTIFF

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT

[Filed: June 23, 1995]

OPINION AND ORDER

POTTER, J.:

This action is before the Court on the parties' cross motions for summary judgment, their oppositions, and plaintiff's reply. This is an action challenging the validity of a Medicare regulation which implements a new statutory payment methodology for graduate medical education (GME) costs incurred by teaching hospitals.

Under the Federal Rules of Civil Procedure, summary judgment is proper only where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). The Supreme Court has

> recently stated that the inquiry is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson v. Liberty Lobby, Inc.*, 106 S. Ct. 2505, 2512 (1986). . . . In reviewing a motion for summary judgment, however, all inferences "'must be viewed in the light most favorable to the party opposing the motion.'" *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 106 S. Ct. 1348, 1356-57 (1986) (quoting *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962)).

Ralph Shrader, Inc. v. Diamond International Corp., 833 F.2d 1210, 1213 (6th Cir. 1987).

> *Matsushita* demands only that the nonmoving party's inferences be reasonable in order to reach the jury, a requirement that was not invented, but merely articulated in that decision. If the [nonmoving party's] theory is . . . senseless, no reasonable jury could find in its favor, and summary judgment should be granted.

Eastman Kodak Co. v. Image Technical Servs., Inc., 112 S. Ct. 2072, 2083 (1992) (footnote omitted).

The party moving for summary judgment "always bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits if any' which [he] believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). The substantive law of the case identifies which facts are material. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Therefore, only disputes

of facts affecting the outcome of the suit under the applicable substantive law will preclude the entry of summary judgment. *Id.* A moving party may discharge its burden "by 'showing'—that is, pointing out to the district court—that there is an absence of evidence to support the nonmoving party's case." *Celotex*, 477 U.S. at 324-325. Where the moving party has met its initial burden, the adverse party "must set forth specific facts showing that there is a genuine issue for trial." *Anderson*, 477 U.S. at 250.

> [W]here the nonmoving party will bear the burden of proof at trial on a dispositive issue, a summary judgment motion may properly be made in reliance solely on the "pleadings, depositions, answers to interrogatories, and admissions on file." . . . Rule 56(e) therefore requires the nonmoving party to go beyond the pleadings and by her own affidavits, or by the "depositions, answers to interrogatories, and admissions on file," designate "specific facts showing that there is a genuine issue for trial."

Celotex, 477 U.S. at 324.

At issue in this case is the proper construction of a provision in 1986 legislation establishing a new Medicare payment methodology for GME costs effective for cost reporting years beginning on or after July 1, 1985. The new methodology provides for GME cost reimbursement to be made by "formula" rather than utilizing the prior pass through method of reimbursing reasonable GME costs. A brief history of the legislation and the regulations implementing the statute is necessary to understand the issues involved in this case.

Part A of the Medicare program provides insurance for covered inpatient hospital and related post-hospital services. When eligible patients receive these services, the Secretary of Health and Human Services (Secretary) reimburses the service providers. Under the Medicare regulations, the costs of programs for interns and residents known as graduate medical education programs are "allowable costs" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a). Until 1983, the Medicare program reimbursed participating hospitals the "reasonable cost" incurred in furnishing services to Medicare patients. 42 U.S.C. § 1395x (v)(1)(A). The reasonable cost calculation generally was based on the costs actually incurred. *Id.*

Effective for cost reporting years beginning on or after October 1, 1983, Congress adopted a prospective payment system (PPS) to reimburse most hospitals for inpatient operating costs. 42 U.S.C. § 1395ww(d). However, Congress retained the "reasonable cost" reimbursement system for certain hospital costs, including the costs of medical education. *See generally*, 42 U.S.C. § 1395ww(a)(4).

In April, 1986, Congress enacted legislation establishing a new GME cost reimbursement system. Pub. L. No. 99-272, 100 Stat. 153-55, 42 U.S.C. § 1395ww(h). The law provides that the "Secretary shall determine, for each hospital . . ., an approved FTE [full time equivalent] resident amount for each cost reporting period beginning on or after July 1, 1985." *Id.* The per resident amount is the average amount recognized as reasonable during a base period that began in fiscal year 1984, updated each year by an inflation factor. *Methodist Hospital v. Sullivan*, 799 F. Supp. 1210, 1211-12 (D.D.C.1992); 42 U.S.C. 1395ww(h)(2).

The actual GME payment is then determined for the period by multiplying the hospital-specific per resident amount by the average number of residents in the hospital's residency program for that period. The Secretary then multiplies that product by the hospital's Medicare patient load for the period. *Methodist Hospital*, 799 F. Supp. at 1212; 42 U.S.C. 1395ww(h)(3). Thus, all GME cost reimbursements for fiscal years beginning on or after July 1, 1985 are based on the costs recognized as reasonable in fiscal year 1984.

On September 29, 1989, the Secretary issued final regulations implementing the new GME reimbursement rules established in the 1986 statute. *See* 54 Fed. Reg. 40286 (codified at 42 C.F.R. § 413.86). These regulations directed fiscal intermediaries (usually insurance companies) to "verify" or reaudit hospitals' base-period GME costs, excluding any non-allowable or misclassified costs. 42 C.F.R. 413.86(e)(1)(ii). However, by September, 1989, virtually all hospitals had already received a notice of program reimbursement (NPR) from their intermediaries, and in most cases, the regulatory three year period for reopening an intermediary's determination had expired. *See Administrators of Tulane Educ. Fund v. Shalala*, 987 F.2d 790, 793 (D.C. Cir. 1993). Acknowledging this limitation, the Secretary provided that "[i]f a hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount." 42 C.F.R. § 413.86(e)(1)(iii). The Secretary also stated that "no new reimbursement principles will be applied during the reaudit." 54 Fed. Reg. 40,301. The intermediaries are to issue a notice of average per resident amount for the hospital's base

year after completing the reaudits. The hospital then has 180 days from the date of the notice to file an appeal with the Provider Reimbursement Review Board (PRRB) if dissatisfied with the intermediaries determination. 42 C.F.R. § 413.86(e)(1)(v).

The undisputed facts specific to plaintiff in the case sub judice reveal plaintiff's GME base year to be the fiscal year ending December 31, 1984. The NPR for 1984 was issued by plaintiff's intermediary on February 26, 1986 and became final on February 27, 1989 after the three year reopening period expired. The record keeping provision of the regulations required plaintiff to keep its records documenting its 1984 physician compensation costs until January 1, 1989.[1] *See* 42 C.F.R. § 405.481(g).

Plaintiff's Medicare intermediary began reauditing plaintiff's base year in late 1990 and issued a notice of average per resident amount for the base year on January 31, 1991. The intermediary determined that plaintiff's allowable base year costs were significantly lower than its determination in the 1986 audit of plaintiff's 1984 costs. Plaintiff timely appealed the intermediary's determination to the PRRB contending that the Secretary's regulations are invalid to the extent that they permit a determination of allowable GME base year costs for purposes of the new payment methodology on the basis of reaudited GME costs rather than using the "reasonable cost" determination resulting from the 1986 audit. The PRRB determined that it did not have the authority to decide the validity of the Secretary's reaudit regulations and granted plaintiff permission to obtain judicial review.

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[1] Physician compensation costs are a major component of the GME costs.

Initially, the Court notes that plaintiff's administrative appeal challenged only the facial validity of the Secretary's reaudit regulations.[2] Thus, the Court is precluded from considering issues not raised first before the PRRB. *See* 42 U.S.C. § 1395*oo*(f)(1). *See also Heckler v. Ringer*, 466 U.S. 602, 614-617 (1984).

In its motion for summary judgment, plaintiff contends that the Secretary's reaudit regulation is invalid as contrary to the plain meaning of the statute, as an unreasonable interpretation of the statute, and as an invalid retroactive regulation. Defendant contends that the Medicare statute is ambiguous, that the regulations reflect a reasonable interpretation of the statute, and that the regulation has no impermissible retroactive effect.

The ultimate issue in this action is the proper construction of the GME statute. When reviewing an agency's construction of a statute which it administers, a court must first determine

> whether Congress has directly spoken to the precise question at issue." If the intent of Congress is clear . . . the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. . . . [I]f the statute is silent or

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[2] Plaintiff has not provided the Court with a record of the administrative appeal. However, the only argument apparently raised administratively was the fact that the GME base year was no longer subject to reopening and, thus, the intermediary must apply allowable GME costs found in the 1986 audit. *See* Complaint at ¶ 40. Plaintiff did not raise any procedural claims or challenge the implementation of the regulations and any resulting prejudice (i.e. that its intermediary used standards other than those that were in effect in 1984 when conducting the reaudit or that the delay in its intermediary's reaudit report caused it any prejudice).

> ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842 (1984).[3] "The Court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of the agency." *Good Samaritan Hosp. v. Shalala*, 873 F. Supp. 1083, 1087 (S.D. Ohio 1994).

The pertinent portion of the statute at issue provides as follows:

> The Secretary shall determine, for the hospital's cost reporting period that began during fiscal

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[3] Plaintiff cites *Health Ins. Assoc. of America, Inc. v. Shalala*, 23 F.3d 412, 425 (D.C. Cir. 1994), for the proposition that the Secretary's reaudit regulation is not entitled to the deference set forth in *Chevron* due to the retroactive nature of the regulation. Plaintiff's argument for this purpose does not distinguish between retroactivity that is expressly authorized by statute and retroactivity that is not so authorized. For example, plaintiff states that the regulation is retroactive because it applies to cost reporting years beginning on or after July 1, 1985. However, such retroactivity is expressly authorized by statute. *See* 42 U.S.C. § 1395ww(h)(2). Plaintiff also claims retroactivity because the regulations "repealed the reopening and document-retention standards applicable to 1984." Plaintiff's Memorandum at p. 15. However, in *Health Ins. Assoc. of America*, the court accorded no deference to interpretive agency rules which allowed it to seek recovery of funds with respect to transactions that occurred before the effective date of the rules and which were not authorized by statute. Because this Court finds, as discussed later in this opinion, that the reaudit regulations are retroactive only to the extent authorized by statute, plaintiff's argument is without merit.

> year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

42 U.S.C. § 1395ww(h)(2)(A). Plaintiff first contends that the statutory phrase "amount recognized as reasonable under this subchapter" clearly and unambiguously refers to the amount established in the NPR upon completion of the normal audit and review process. Defendant, on the other hand, argues that the phrase is ambiguous in that Congress did not specify whether the "amount recognized as reasonable" refers to a present recognition of reasonableness using 1984 standards or a past recognition of the amount thought to be reasonable when the base year costs were submitted by providers and reimbursed by the Secretary.

Only two courts have previously addressed the proper construction of Section 1395ww(h)(2)(A), each reaching a different conclusion. In *Methodist Hospitals v. Sullivan*, 799 F. Supp. 1210 (D.D.C. 1992), the district court concluded that the plain meaning of the statute does not authorize a reaudit of the 1984 base year costs. The district court concluded that Congress must have known of the process of review that the provider's figures normally receive and found that "Congress could not have intended that the Secretary interpret 'recognized as reasonable' to mean two amounts for fiscal 1984: one derived from the standard cost reporting and review process following the close of the fiscal year, and a lower figure recalculated once the Secretary realized that the year would become the base-year for subsequent determinations." *Id.* at 1217-1218. The court found that the

framework of the statute as a whole supported its conclusion. It reasoned that, while Congress expressly granted the Secretary the authority to establish rules for computing the number of FTE residents, the statute nowhere authorizes rules to determine the amount of costs recognized as reasonable. *Id.* at 1218.

The *Methodist Hospital* district court opinion was reversed in *Administrators of Tulane Educ. Fund v. Shalala*, 987 F.2d 790 (D.C.Cir 1993).[4] The *Tulane* court found that the statutory text does not address the issue of whether a fresh determination of 1984 GME costs may be made after the expiration of the reopening period in order to establish an accurate base period per resident amount. The Court concluded that "the most natural assumption to be drawn from the statutory silence on the subject would be that Congress did not mean to preclude HHS from correcting past mistakes in the 1984 figure which would govern subsequent payments." *Id.* 795. The court also believed the phrase "amount recognized as reasonable" to be ambiguous on its face. The court found that use of the 1984 figures for the indefinite future weighed "against a reading of the phrase that allows no elbow room for adjustments based on prior miscalculations or errors." *Id.* at 796.

Although plaintiff urges the Court to adopt the district court's reasoning in *Methodist Hospital* that the GME statute's framework as a whole supports a finding that Congress clearly did not intend to authorize a reaudit of 1984, the Court is persuaded otherwise. While the statute expressly provides for

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[4] On appeal, *Methodist Hospital* was captioned *Administrators of Tulane Educ. Fund v. Shalala.*

rule making authority with respect to calculating the number of FTE residents and provides no such authority with respect to the "amount recognized as reasonable," the FTE figure was an entirely new concept in the GME reimbursement methodology. *Id.* at 795 n.5. "By contrast, the concept of reasonable costs already was a mainstay of Medicare statutes and regulations, *see* 42 U.S.C. § 1395x(v), 42 C.F.R. § 405.1803, and there was no need to establish any new rule making authority for its determination." *Id.*

Plaintiff also argues that the Secretary did not conduct reaudits in determining amounts pursuant to other provisions of Section 1395ww enacted a few years earlier in which similar language was used.[5] Therefore, plaintiff argues, construing the statute to allow a reaudit in this instance will result in the inconsistent construction of identical words in other provisions of Section 1395ww. However, the Secretary's construction of Section 1395ww(h)(2)(A) is not inconsistent simply because the Secretary did not consider a reaudit necessary for other base year calculations. The calculations to which plaintiff refers involve a base year other than 1984 and do not involve GME costs. However, with respect to GME reimbursements, the Secretary was made aware of several situations in which hospitals were reim-

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[5] For example, in enacting laws limiting operating cost reimbursements, Congress specified that the limit "shall in no event be lower than the allowable operating costs of inpatient hospital services . . . recognized under this subchapter for such hospital for such hospital's [base year]." 42 U.S.C. § 1395ww(a)(1)(C). Another limit (denoted the "target amount") was defined in terms of "the allowable operating costs of inpatient hospital services . . . recognized under this subchapter for such hospital for [the base year]." 42 U.S.C. § 1395ww(b)(3)(A)(I).

bursed for misclassified and/or non-allowable costs. *See* 54 Fed. Reg. 40300. In other words, if the Secretary was not aware of errors in other base year cost determinations, a regulation providing for a reaudit of that base year was unnecessary. The fact that the Secretary's decision may vary in the context of particular cost determinations does not mean there is an inconsistency in her construction of similar statutory language.

After carefully reviewing the arguments presented, the Court concludes that neither the plain language, the statutory framework, nor the Secretary's construction of other provisions of Section 1395ww require a statutory construction prohibiting the Secretary from reauditing 1984 GME costs. That Congress did not intend to preclude the correction of past mistakes in the 1984 figure is buttressed by the legislative history which indicates that the objective of the GME Amendment is to "*limit payments* to hospitals for their direct costs of approved medical education activities" for cost reporting years beginning on or before July 1, 1985. Senate Comm. on Finance, 99th Cong., 2d Sess, Report on Budget Reconciliation Act of 1986 (Comm Print 1985), *reprinted in* 1986 U.S.C.A.A.N. 251, 259; *see Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."). Thus, the Court agrees with the *Tulane* opinion that the statute is silent or ambiguous with respect to the specific issue in question. The question then for the Court is whether the Secretary's interpretation is a permissible construction of the statute.

Plaintiff maintains that it was unreasonable for the Secretary to believe that the reaudit would result in a more accurate determination of GME costs than the original 1986 audit. However, as noted above, the Secretary was made aware of several situations in which misclassified and non-allowable costs were reimbursed as GME costs. The Secretary attributed this to the fact that "GME costs were not given sufficient scrutiny at the time because of the many changes taking place in Medicare generally." 54 Fed. Reg. 40301 (1989). The Secretary believed that Congress did not intend for misclassified and non- allowable costs to be permanently ingrained in future reimbursements. *See Id.* The Court finds the Secretary's belief to be reasonable and consistent with the congressional purpose of limiting payments to hospitals for such costs.[6] *See Tulane*, 987 F.2d at 797.

Because the three year period for reopening 1984 reimbursement determinations had closed, the Secretary reasonably provided that its reauditing would not impact actual 1984 reimbursements. Furthermore, the Secretary provided reasonable notice to providers that documentation would be requested by their intermediaries to support their reported 1984 costs. *See* 53 Fed. Reg. 36,592 (1988). This notice was provided before the expiration of the four year period during which plaintiff was required to maintain the

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[6] Because it is reasonable to believe that congress did not intend for misclassified and non-allowable costs to be recognized indefinitely, the Court also rejects plaintiff's argument that it is irrational to assume that Congress intended the Secretary to ignore settled principles of res judicata and collateral estoppel with respect to 1984 cost determinations.

necessary documentation.[7] However, not all hospitals heeded the notice, and the Secretary later discovered that records for some hospitals no longer existed. *See* 55 Fed. Reg. 36,063 (1990). Although plaintiff argues that the Secretary then allowed intermediaries to audit years other than the base year to determine the per resident GME costs in contravention of the statute, no such authority was given. Rather, the Secretary merely allowed hospitals, in the absence of base period documentation, to furnish documentation from the subsequent cost reporting period closest to the GME base period. *Id.* The Secretary stressed that such documentation is, "at best, persuasive evidence rather than conclusive evidence," and "if the intermediary believes that any of the changes or modifications distort the reliability of the data, it will make whatever adjustments are necessary to ensure an accurate cost allocation." *Id.* at 36064. The Court believes that the Secretary's solution to the records problem is reasonable.

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[7] Section 405.48(g) of 42 C.F.R. requires hospitals to [r]etain each physician compensation allocation, and the information on which it is based, for *at least* four years after the end of each cost reporting period to which the allocation applies." (Emphasis added.) By its terms, plaintiff was required to maintain its 1984 records until January 1, 1989. However, the reopening period for plaintiff's 1984 cost determination did not expire until February 27, 1989. It appears that the Secretary could have reaudited after January 1, 1989 and required plaintiff to provide 1984 supporting documentation since plaintiff was on notice that it could be reaudited. Likewise, the Secretary's notice in the proposed regulation issued in 1988 that the hospital's GME cost determinations for their base year would be reaudited put plaintiff on notice that documentation for that year should be maintained.

Plaintiff also argues that it is irrational that the reauditing process may lead to two different, but equally allowable, determinations of a hospital's base year GME costs. However, the Court does not agree. The Secretary could have corrected errors made in determining reasonable base year GME costs in order to recoup non-allowable or misclassified costs in the base year if the cost determinations had been reopened within the three year window. *See Good Samaritan Hosp. v. Shalala*, 873 F. Supp. 1083, 1089 (S.D. Ohio 1994). Thus, the 1986 determinations of base year GME costs are "allowable" only because the reopening period has expired. However, because the Secretary can no longer recoup reimbursements for the base year which were made in error does not render correcting such errors irrational when the corrected amount will only be applied in cost reporting years still subject to reopening. Rather, the Court finds that two different, but equally "allowable," determinations of a hospital's base year GME costs is reasonable.

Finally, plaintiff argues that the reaudit regulation is impermissibly retroactive. The 1986 GME Amendment, by its very terms, is intended to have some retroactive effect as it applies to cost reporting years beginning on or after July 1, 1985. However, plaintiff argues that the reaudit regulation adds retroactive effect not inherent in the statute. Specifically, plaintiff argues that the regulation retroactively rescinded the three-year reopening period and the four-year record retention period applicable to 1984 costs. In addition, plaintiff argues that the regulation retroactively rescinded the consistency rule set forth in Section 412.113(b)(3) and the regulation governing

the finality of the PPS hospital-specific rate set forth in Section 412.71(d).

A law or regulation is retroactive if it "takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past." *Tulane*, 987 F.2d 790. However, a law is not retroactive "merely because it draws upon antecedent facts for its operation." *Landgraf v. USI Film Products*, 114 S. Ct. 1483, 1499 n. 24 (1993).

In *Tulane*, the court found that the reaudit regulations are not impermissibly retroactive. The court concluded that, "within the limited statutory retroactivity, the Secretary's reauditing regulations add nothing further that is retroactive: the regulations contemplate only the use of past information for subsequent decision making."[8] *Tulane*, 987 F.2d at 798.

This Court agrees that the reaudit regulations are not an exercise in impermissible retroactive rule

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[8] In *Methodist Hospitals*, the district court found the reaudit regulations to be impermissibly retroactive. The court based this finding solely on the fact that the agency was without power to institute new audit requirements. *Methodist Hospital*, 799 F. Supp. At 1219. This argument, while raised in plaintiff's complaint, is not raised in its motion for summary judgment. In any event, nowhere in the regulations are new audit requirements found. Rather, in the preamble to the regulations, the Secretary responded to a concern that different standards would be applied on audit that were not applied originally by stating that "our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied" and that "no new reimbursement principles will be applied during the reaudit." 54 Fed. Reg. 40,286 (1989).

making. Although the regulation permits a reaudit of base year GME costs, the effect of the reopening of the 1984 cost report has no retrospective impact other than that mandated by statute (i.e. the results of the reaudit are applied only to cost reporting years beginning on or after July 1, 1985). Furthermore, the regulation does not revoke the record keeping requirements in effect in 1984. Rather, the Secretary has recognized this requirement and has provided an alternative method for documenting base year costs, as discussed above, in the event that hospitals did not retain the necessary records.

Plaintiff also argues that the reaudit regulation retroactively rescinded the "consistency rule" promulgated by the Secretary in implementing the prospective payment system (PPS) for reimbursement of inpatient operating costs. The PPS was phased in over a four-year period. During this time, hospitals were paid a blend of two rates for operating costs: the "hospital-specific rate." (HSR) and the federal rate.[9] The consistency rule provided that

> For cost reporting periods beginning prior to October 1, 1986, the costs of medical education must be determined consistently with the treatment of such costs for purposes of determining

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[9] The HSR was based on the specific hospital's historical costs in a given base year and constituted a progressively declining portion of Medicare's reimbursement for operating costs. *See Good Samaritan Hosp. v. Shalala*, 873 F. Supp. 1083, 1085 (S.D. Ohio 1994). The federal rate was based on a regional and/or national rate per discharge and constituted a progressively increasing portion of the reimbursement for operating costs. *Id.*

> the hospital-specific portion of the transition payment rate [in the PPS].

42 C.F.R. § 405.477(c)(2) (1984).[10]

An agency's interpretation of its own regulations is entitled to considerable deference. The court must give that interpretation controlling weight unless it is "plainly erroneous or inconsistent with the regulation." *Thomas Jefferson Univ. v. Shalala*, 114 S. Ct. 2381, 2386 (1994). The consistency rule was designed "to prevent hospitals from claiming amounts on a reasonable cost basis for the types of costs already included in its HSR." 54 Fed. Reg. 40302; 53 Fed. Reg. 38517. "It was never intended to recognize operating costs misclassified as GME costs." 54 Fed.Reg. 40302. Rather, the rule was intended to ensure that reclassification of costs would be *minimized* during the transition period. 53 Fed. Reg. 38476. The Secretary's interpretation is not plainly erroneous or inconsistent with the regulation. *See Good Samaritan Hosp.*, 873 F. Supp. at 1089) (consistency rule did not preclude the reclassification of erroneously classified GME costs pursuant to the reaudit regulation.) Accordingly, the Court finds that the reaudit regulation does not retroactively rescind the consistency rule.

Likewise, the Court finds that the regulation governing the finality of the PPS hospital-specific rate set forth in Section 412.71(d) is not retroactively rescinded by the reaudit regulation. Section 412.71(d) provides as follows:

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[10] Section 405.477(c)(2) was later redesignated 42 C.F.R. § 412.113(b) and modified to read, "Except as provided in 413.86(c)(1) of this chapter, for cost reporting periods. . . ."

> The intermediary uses the best data available at the time in estimating each hospital's base-year costs. . . . The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.[11]

Because the Secretary's regulation allows *hospitals* to request an adjustment to their PPS hospital-specific rates in order to reflect reclassification of costs in the GME reaudit, *see* 42 C.F.R. § 413.86(j)(1), plaintiff contends that the regulation is impermissible retroactive. The Court, however, finds this argument without merit. Pursuant to Section 413.86(j)(1), the PPS hospital-specific rate can only be adjusted *upward* at the request of the hospital. Hospitals can only benefit from that provision. Section 413.86(j)(1) creates no new obligations or disabilities and, as such, cannot be found to be impermissibly retroactive.

Accordingly, the Court finds that the reaudit regulation is not impermissibly retroactive and that it reflects a reasonable interpretation of the GME amendment.

THEREFORE, for the foregoing reasons, good cause appearing, it is

ORDERED that plaintiff's motion for summary judgment be, and hereby is, DENIED; and it is

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[11] The exceptions provided in section 412.72 are not applicable in the case sub judice.

FURTHER ORDERED that defendant's motion for summary judgment [Doc. Nos. 30 and 31] be, and hereby is, GRANTED.[12]

/s/ JOHN W. POTTER
Sr. United States District Judge

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[12] Defendant filed two identical motions for summary judgment [Doc. Nos. 30 and 31]; however, the second motion included attached exhibits.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 95-3858

THE TOLEDO HOSPITAL, PLAINTIFF-APPELLANT

v.

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLEE

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO

[Filed: Mar. 27, 1997]

ORDER

Before: BOGGS and NORRIS, Circuit Judges; HOOD, District Judge.*

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this

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* Hon. Joseph M. Hood, United States District Judge for the Eastern District of Kentucky, sitting by designation.

court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ LEONARD GREEN
LEONARD GREEN, Clerk

APPENDIX D

1. Section 1395ww(h) of Title 42 of the United States Code provides in relevant part:

(h) Payments for direct graduate medical education costs

* * * * *

(2) Determination of hospital-specific approved FTE resident amounts

The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

(A) Determining allowable average cost per FTE resident in a hospital's base period

The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this subchapter for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

* * * * *

2. Section 405.1885(a) of Title 42 of the Code of Federal Regulations provides:

Reopening a determination of decision.

A determination of an intermediary * * * may be reopened with respect to findings on matters at issue in such determination * * *, by such intermediary officer * * *, either on motion of such intermediary officer * * * or on the motion

of the provider affected by such determination * * * to revise any matter in issue at any such proceedings. * * * [A]ny such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination * * * may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

* * * * *

3. Section 413.86 of Title 42 of the Code of Federal Regulations provides in relevant part:

Direct graduate medical education payments.

* * * * *

(e) *Determining per resident amounts for the base period*—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. * * *

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

* * * * *